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AUTHOR Belgarde, Mary Jiron; LaFromboise, Teresa
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ABSTRACT

This paper provides information regarding a joint curriculum project between Stanford University and the Pueblo of Zuni in New Mexico. The project is an outgrowth of the Stanford/Zuni Committee, a unique collaborative effort that is guarded by sensitivity to previous Indian research experiences and a commitment to useful consultation with the tribe. This report presents the epidemiology of Zuni suicide and notes that the suicide rate of Indian youth is three times that of white youth. Treatment programs used in other reservation communities are briefly reviewed. The document describes the Stanford prevention strategy, which uses a social skills training model. The project operates under the belief that favorable outcomes could result from the use of an intervention that focuses primarily on developing in students the independent use of target skills outside the school context. Although the project is not complete, it is hoped that Zuni students will be able to regulate their own behavior better as they acquire the transactional skills of coping. The project's curriculum and proposed implementation plan are described in detail. (TES)

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Zuni Adolescent Suicide

Mary Jiron Belgarde and Teresa LaFromboise

Stanford University

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ZUNI ADOLESCENT SUICIDE

Introduction

This paper provides information regarding a joint curriculum project between Stanford University and the Pueblo of Zuni in New Mexico. The project is an outgrowth of the Stanford/Zuni Committee, a unique collaborative effort that is guarded by their sensitivity to previous Indian research experiences and a commitment to useful consultation with the tribe. A description of the epidemiology of Zuni suicide is presented, treatment programs used in other reservation communities are briefly reviewed and a description of our prevention strategy utilizing a social skills training model including the curriculum and implementation plan is described in detail.

Zuni Pueblo Description

Zuni Pueblo is a traditional Indian village of about 7,000 people located in western part of New Mexico. The economy is based upon agriculture, sheep-herding, silversmithing, and sporadic wage labor. The majority of pre-school children grow up speaking the Zuni language. The school system is now part of the county-wide public school system headed by a tribal member, Mr. Hayes Lewis.

Like many other Indian tribes, Zuni suffers from various forms of oppression from the dominant society. The Pueblo is concerned with economic hardships, unemployment, teenage pregnancy, adolescent suicide, and other health related problems such as alcoholism, diabetes, end-stage renal disease (not related to diabetes). The Stanford/Zuni Committee has grappled

with a number of problem areas and tried to lend assistance in the development of a suicide prevention program; the creation of a management training program for the tribal council and administrative staff; the study of Zuni archeology, flint tool making, establishment of cultural resource management program and museum; as well as, educational programming for their radio station.

Stanford/Zuni Committee

The Stanford/Zuni Committee is composed of faculty and students from the Stanford Schools of Education, Communication, Business, Anthropology, English, Statistics, and Medicine and administrative staff from the Provost Office. Various project representatives have met on numerous occasions with the Pueblo Governor, tribal council, program administrators, and community members at Zuni. Zuni representatives have been our guests at Stanford to help identify research needs, explain local perspectives, and receive training. Dr. Teresa LaFromboise, Stanford faculty member in Counseling Psychology and her research team met with the Pueblo Governor, tribal council, school board, school personnel, and Indian Health Service officials before designing the suicide prevention program and will continue to consult with representatives from the Zuni Public Schools as the program is implemented and evaluated.

Zuni Adolescent Suicide

Serious consideration of Indian suicide rates is confounded by the limited statistical information that has been used to

describe the epidemiology of suicide by age and race categories. The matter is further complicated in that Indian and adolescent epidemiologic data on suicide was gathered through a variety of data collection efforts that did not occur within the same period of time. The convention of calculating suicide rates is per 100,000. Since the size of Indian communities are smaller than 100,000, modest changes in raw numbers can transform suicide rates into large numbers. However, tribal diversity should be noted since there has been no suicidal occurrences in some Indian communities and a significantly high number of suicidal occurrences in other communities. 1986 Indian Health statistics on suicide reveal that overall Indian suicide rates range from 6 per 100,000 for one tribe in California to 49 per 100,000 in Tucson, Arizona (Indian Health Service Report, 1987). In some Indian communities with high suicide rates it has been noted that certain families repeatedly account for a significant proportion of the incidences.

Past studies of Indian adult suicide have concluded that Indian adult suicide rates are 2 times the national average, when compared to U.S. White adults. The suicide rate of Indian youth is 3 times that of White youth. The overall Zuni suicide statistics in 1986 were 37.5 per 100,000 which is compatible to 38.9 of the New Mexico Indian adolescent statistics of 1981-83 and twice as high as the 19.6 New Mexico White adolescent population suicide rate for the same period.

Other Preventative and Treatment Programs

Given the magnitude of this problem, it was unfortunate to discover that Indian adolescent suicide prevention programs are virtually non-existent in the suicide literature. Treatment programs with Indian adolescents are employed after suicide attempts have been made but little has been written about them. Many suicide attempters are paired with Indian elders and family for support and exploration of future contributory roles. The intervention programs utilize collaborative decision making, future planning, illusional control, and social support to enhance coping effectiveness when the desire to commit suicide occurs. In general, these interventions have reduced the incidence of suicide among the tribes who employed them (Berlin, 1985; Ward, 1984). A major limitation of these programs is their focus on end-stage behaviors associated with the suicide attempt. These programs do not help adolescents understand explicitly the dynamics of coping with stress and depression or guide them in acquiring skills for effective living.

Social Skills Training

Social skills training has proven effective in problem areas relevant to Indian people, such as: assertiveness, problem solving, job interviewing, parenting, substance abuse, and leadership (Bigfoot, 1987; Bobo, 1985; LaFromboise, 1980; LaFromboise & Boesch, 1987; LaFromboise & Rowe, 1983). Components of the skills training curriculum include an elaborate, well-planned rationale for designing the program,

community defined target problems and targeted skills, and supportive community feedback and reinforcement for alternative ways of coping. Culturally adapted skills training models merge Indian belief systems with skills acquisition to enrich and enhance the capabilities of Indian people. The individual achieves a desired level of competence, expanding their repertoire of coping and mastery behaviors. Skills training increases their use of alternative strategies that can be used in diverse situations and cultural contexts. For example, a Zuni youth might learn how to help identify positive cultural events for his grieving family rather than punish himself for having overlooked a family member's suicidal gestures.

Skills training is based on a social cognitive theory which posits that behavioral interactions of individuals are learned within the social milieu and maintained through cognitive and social reinforcement (Bandura, 1986). Social skills training assumes that, regardless of the reason that an individual may not have learned how to handle certain interpersonal interactions and coping events successfully, the person can be taught more effective behavior if the desired competencies are identified clearly and if learning principles are systematically applied to refine them (Kelly, 1982). When applied to suicide prevention the model emphasizes the dynamic relationship between students and their environment as students appraise what is at stake (eg. in terms of values, goals, beliefs, commitment) and what coping resources are available to manage the situation. As difficult

thoughts and feelings are reframed into more understandable and controllable events during the suicide prevention program, the relationship between Zuni students and the environment causing the distress is altered.

The cognitive, behavioral, and emotional problems nominated by members of the research team and Zuni representatives were based on knowledge and experience with Zuni life and reviews of the Indian counseling literature. The targeted cognitive problems included negative views of self, the world, and the future. The behavioral problem targeted was the normalization of self-destructive behaviors. The emotional problems were restraint of emotions and acculturation conflicts. Other problems will be further enumerated in subsequent phases of the program, particularly after the curriculum as been field tested. The specific skills training selected to address these targeted problems and skills were suicide prevention and the cognitive modification of hopelessness, anger, and depression. In subsequent stages of training Zuni faculty, students, suicide task force members, and other concerned community representatives will further identify skills necessary for effective living at Zuni.

Curriculum

In Phase I of the curriculum, Carolyn Harris, a graduate student in medical anthropology and experienced health educator on suicide adapted an adolescent suicide workshop for Zuni from previous workshops used in the San Bernadino schools. She

presented this workshop to the student body, faculty and staff at two Zuni high schools during the fall of 1987. At that time, she administered various instruments to students that should add to the body of literature on Indian adolescent suicide. The measurement instruments were the Beck Depression Scale, Center for Epidemiologic Study - Depression (CES-D), Ways of Coping Scale (Lazarus & Folkman, 1984), and pre and post tests related to the content of the major suicide prevention concepts.

In Phase II of the curriculum, approximately 35 interactive lessons were developed employing a social skills training model. This model includes imparting information on target behaviors, modeling, behavior rehearsal, and supportive feedback. Ten of the lessons provide knowledge on suicide prevention and include the following: the rationale for studying suicide; ways of understanding suicide rates; the cognitive, behavioral, and emotional signs and symptoms associated with suicide; the facts and myths about suicide; and selected peer counseling interventions for suicide. The lessons are basic and tailored for acceptability at Zuni. The information is applicable to ages 12-24 and involve Indian elders to reinforce traditional beliefs that prohibit suicide as an acceptable form of coping with despair. The environmental antecedents are emphasized early on so that students understand that suicide is not an Indian problem but a problem that affects all cultures, socio-economic groups, and ages. The underlying message, is that suicide is unnecessary and preventable.

The remaining lessons provide students with communication and coping skills. Students learn to speak and listen concretely, use anger regulation techniques, manage stress and depression, use cognitive restructuring procedures to enhance mood, practice strength acknowledgement and confidence development strategies, and set future goals. Most areas are broken down into smaller units lasting 40-50 minutes in length and few lessons are held over multiple sessions.

Most of the lessons involve role play and discussions that are interactive, incorporating situations and experiences relevant to Zuni adolescent life. Moreover, they deal with problems that are of interest to students such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons have scenarios that allow students to employ critical and practical thinking, as well as, apply knowledge relevant to suicide.

In a lesson on depression, students learn that depression is a psychological symptom often associated with suicide. They also learn that depression accounts for as much as 40 percent of the daily patient case loads in many Indian health care clinics. Accurate diagnosis of depression is complicated by it´s occurrence with alcoholism, antisocial behavior, physical illness, and prolonged grief experience, each of which is common among American Indians. Historically, American Indians have had many oppressive situations to cope with, such as, the taking of Indian lands and placing of Indian people on reservations and

boarding schools. Students are reminded that American Indians must also deal with problems encountered in daily living, such as: death, divorce, rejection, and threats to self esteem. Typically suicidal depression is different from normal depression and suicidal depression involves very strong and intense feelings over a long period of time.

Since American Indians use rich and varied language forms (words and phrases) for describing mental, emotion, and spiritual states of being, it is possible that American Indians may understand depression in a different manner than that of the American society in general. Drawing from the research of Manson, Shore, and Bloom (1985) students learn five categories of Hopi Pueblo depression: worry sickness (wu wan tu tu ya/wu ni wu); unhappiness (ka ha la yi); heartbroken (uu nung mo kiw ta); drunkenlike craziness (ho nak tu tu ya); and turning one's face to the wall (go vis ti). They also learn knowledge about depression relevant to most non-Indian cultures. Students learn feelings, thoughts, and behaviors that accompany normal depression. Finally, they are given a checklist of things to do and consider in combatting depression and taught methods of self-reinforcement for use when they employ these coping methods.

In another lesson entitled, Dealing with Anger, Part I, students use a quote from a Gallup newspaper article which stated that "most suicides and attempts [are] not merely depression but anger turned inward" to learn about anger regulation. Students learn how to deal with anger by identifying external events

(where, who, and what); internal events (thoughts and feelings); and the actions taken (hostility or suppression) prior to restructuring their thought patterns to diffuse anger in Dealing with Anger, Part II. The teacher models his or her personal diffusion of anger and cognitive restructuring by relating an event that made the teacher angry. The teacher recalls feelings, pictures, and words to describe the angry event and then demonstrates how to use positive opposites to change angry feelings. A suggested story about being run off the road by a drunken driver is provided for the teacher in the event that the teacher chooses not to use a personal story. Students observe the teacher model cognitive restructuring, practice it, receive feedback and support from the teacher, and develop expectancies that they can successfully use outside of the classroom.

Finally, we hope to design lessons for teachers that define their role in this program as educators not therapists, instruct them on methods of assessing lethality and other predictive factors associated with suicide attempts, encourage creative strategies for intervention with students who are at high risk given limited referral sources at Zuni, and suggest implementation procedures.

Proposed Implementation Plan

In April 1988, the materials will be disseminated to administrators, counselors, teachers, and suicide task force members of the Zuni Public Schools. It is proposed that by June 1988, Mr. Lewis will solicit the reactions from these individuals

and secure their commitment to participate in the field testing process of the curriculum in the fall. Suggestions for implementation will also be requested.

It is proposed that teachers field test the suicide prevention materials during the 1988-89 academic year. Prior to the field testing of the materials, Professor LaFromboise and her research team will provide an implementation workshop for teachers. We hope to receive feedback from teachers regarding implementation problems, accomplishments, and proposed revisions by March, 1989. If all goes well, a second revision will be completed and materials returned to Mr. Lewis by August, 1989.

Conclusion

It is hoped that as Zuni students understand better the transactional process of coping they will become better at regulating their own behavior. They will begin to exercise a repertoire of coping options not previously considered. They will experience a greater sense of freedom than those who feel hopeless in terms of personal efficacy. This freedom will influence in turn their reappraisal of the environment as more responsive to their input. As Zuni students feel more effective, they will become less interested in self-destructive forms of coping and more involved in exercising the influence that is theirs to command.

The use of an intervention that focuses primarily on the independent use of target skills outside of the school context could have an important impact on Zuni life. Anecdotal evidence

relayed by school personnel at the completion of Phase I indicated that Zuni students are now providing informal peer counseling support for one another. There have been no suicide attempts since the completion of Phase I. The collaboration team is optimistic about the responsiveness and interest of Phase II by the community. Continued receptivity relies on the incentives Zuni devises to support change and maintain coping perspectives in daily practices. Hopefully, the flexibility and dedication to collaborative interaction characterized by the Stanford Zuni Committee and this curriculum development project will demonstrate that the technology of social cognitive skills training can be successfully transmitted from one culture to another.

References

Andre, J., & Gchachu, S. (1975, June). Suicide occurrences in an American Indian community. Paper presented at the tenth annual joint meeting of the United States Public Health Service Professional Association. Las Vegas. NV.

Bandura, A. (1986). Social foundations of thought and action. Englewood Cliffs, NJ: Prentice-Hall.

Berlin, I.N. (1985). Prevention of adolescent suicide among some Native American tribes. Annals of the American Society for Adolescent Psychiatry, 12, 77-93.

BigFoot, D.S. (1987). Parent training for American Indian families. Unpublished prospectus presented to the Graduate College of Education, University of Oklahoma, Norman, OK.

Bobo, J. K. (1985). Preventing drug abuse among American Indian adolescents. In L. Gilchrist, S. Schinke (Eds.). Preventing social and health problems through life skills training (pp. 43-54). Seattle, WA: University of Washington Center for Social Welfare Research.

Durkheim, E. (1950). Le Suicide. Glencoe, IL: The Free Press.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Freud, S. (1925). Mourning and melancholia. In J. Rieviere (Trans.). Collected papers, IV. London: Hogarth Press.

Gould, R. E. (1965). Suicide problems in children and adolescents. American Journal of Psychotherapy, 19, 228-246.

Indian Health Service Report, 1987.

Kelly, J. A. (1982). Social-skills training: A practical guide for interventions. New York, NY: Springer.

Kornblith, S.J., Rehm, L.P., O'Hara, M.W., & Lamparski, D.M. (1983). The contribution of self-reinforcement training and behavioral assignments to the efficacy of self-control therapy for depression. Cognitive Therapy and Research, 7, 499-528.

LaFromboise, T. (1983). Assertion training with American Indians. Las Cruces, NM: ERIC Clearinghouse on Rural Education and Small Schools.

LaFromboise, T., & Boesch, K. (1986). Circles of women: Skills training for American Indian professionalization. Washington, DC: Project on Equal Education Rights.

LaFromboise, T., & Rowe, W. (1983). Skills training for bicultural competence: Rationale and application. Journal of Counseling Psychology, 50, 589-595.

Manson, S., Shore, J., & Bloom, J. (1985). The depressive experience in American Indian communities: A challenge for psychiatry theory and diagnosis. In A. Kleinman, & B. Good (Eds.). Culture and depression (pp. 331-368). Berkley, CA: University of California Press.

McIntire, M.S., Angle, C.R., Schlicht, M.L. (1977). Suicide and self-poisoning in pediatrics. Advanced Pediatrics, 24, 291-309.

Peck, M.L., Farberow, N.L., & Litman, R.E. (1985). Youth suicide. New York, NY: Springer.

Rathjen, D.P., & Foreyt, . (Eds.) (1980). Social competence: Intervention for children and adults. New York, NY: Pergamon Press.

Shore, J., Bopp, J., Waller, T., & Dawds, J. (1972). A suicide prevention center on an Indian reservation. American Journal of Psychiatry, 128, 1086-1091.

Trimble, J.E. (1977). The sojourner in the American Indian community: Methodological issues and concerns. Journal of Social Issues, 33, 159-174.

Trimble, J.E., & Medicine, B. (1976). Development of theoretical models and levels of interpretation in mental health. In J. Westermeyer (Ed.). Anthropology and mental health (pp.). The Hague: Mouton.

Ward, J.A. (1984). Preventive implications of a Native Indian mental health program: Focus on suicide and violent deaths. Journal of Preventive Psychiatry, 2, 371-385.

Zeiss, A.M., Lewinsohn, P.M., & Munoz, R.F. (1979). Nonspecific improvement effects in depression using interpersonal skills training, pleasant activity schedules, or cognitive training. Journal of Consulting and Clinical Psychology, 47, 427-439.